

Dental Benefit Policy

Anthem Dental [Pediatric][Family] [Enhanced]

[IMPORTANT NOTE: This policy DOES NOT provide coverage for any dental benefits for individuals age nineteen (19) or older. If you are age 19 or older, you may enroll in this policy so you will have the pediatric dental coverage as required by the Affordable Care Act. If you want coverage for adult dental care, you will need to buy a different plan.]

RIGHT TO CANCEL: You have 10 days from the date of delivery to examine this policy. If you are not satisfied, for any reason, with the terms of this policy, you may return it to us within those 10 days. Return to [Anthem Blue Cross and Blue Shield], PO Box 1115, Minneapolis, MN 55440-1115 by midnight on the tenth day. We will then issue a full refund of any premiums and fees paid, less any payments made for benefits on behalf of you or your dependents.

NOTICE TO BUYER: This certificate provides dental benefits only.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Maine, Inc.
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The Blue Cross and Blue Shield names and symbols are registered marks
of the Blue Cross and Blue Shield Association.

INTRODUCTION

This policy is a legal contract between you, the policyholder (“policyholder”, “you”, and “your”) and Anthem Blue Cross and Blue Shield (“Anthem”, “we”, “us”, and “our”). This policy is governed by the laws of the State of Maine. By paying the first premium and accepting this policy, you agree to be bound by the terms of this policy.

[If you are a policyholder under the age of 18 years old, your parent or legal guardian may not exercise or assert your rights as the policyholder, but your parent or legal guardian will be considered the responsible party and, therefore, will be held liable for all financial and/or contractual obligations of this policy until you are 18 years old.]

We may arrange for others to provide certain administrative services on our behalf, including eligibility determination and premium billing. To ensure efficient administration of your benefits, you must cooperate with them in the performance of their duties.

We agree to provide coverage for benefits as set out in this Dental Benefit Policy.

READ YOUR POLICY CAREFULLY. The entire policy sets forth, in detail, the rights and obligations of both you and Anthem. It is therefore important that you read your entire policy carefully.

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

(If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the customer service number.)

Thank you for choosing Anthem Blue Cross and Blue Shield!



Kathleen S. Kiefer
Corporate Secretary

Administered by:
ANTHEM BLUE CROSS AND BLUE SHIELD
[Administrative Offices
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SUMMARY OF DENTAL BENEFITS

The Summary of Dental Benefits is a summary of the *deductibles*, *waiting periods*, *coverage percentages* and *benefit maximums* that apply when you receive *covered services* from a *dentist*. Please refer to the Covered Services section of this *policy* for a more complete explanation of the specific services covered. All *covered services* are subject to the conditions, exclusions, limitations, terms and provisions of this *policy*, including any attachments or riders.

Coverage Year

A *coverage year* is a 12-month period in which *deductibles* and benefit maximums apply. Your *coverage year* is January 1st through December 31st.

Deductible

The *deductible* is the amount you must pay before we begin to pay for *covered services*. You have to meet your *deductible* every *coverage year* before we will pay for *covered services*.

Deductible amount for members through the end of the month in which they turn 19 \$[25][50] per covered person

[Deductible amount for members age 19 and older.....\$50 per covered person]

Waiting Periods

A waiting period is the length of time you must be covered under this *policy* before we pay benefits. Certain types of services may have waiting periods under your *policy*. You are eligible for benefits once you meet your waiting periods.

Type of Service

Waiting Period

[For covered persons age 19 and older

Basic Restorative	6 months
Endodontic Services	12 months
Periodontal Services	12 months
Oral Surgery Services	12 months
Major Restorative Services	12 months
Prosthodontic Services	12 months]

For covered persons through the end of the month in which they turn 19

Dentally Necessary Orthodontic Care.....	12 months
[Cosmetic Orthodontic Care.....	12 months]

Benefit Maximum

The following benefit maximums are the dollar amount we will pay for *covered services* for each *covered person*, subject to the *coverage percentages* identified above. If you do not reach your annual benefit maximums, unused amounts will not carry over to the next *coverage year*.

	Participating Dentist	Non-Participating Dentist
Annual Benefit Maximum (for covered persons through the end of the month in which they turn 19)	no limit	
Dentally Necessary Orthodontic Care Lifetime Benefit Maximum	no limit	
[Cosmetic Orthodontic Care Lifetime Benefit Maximum	\$1,000 (combined for participating and non-participating dentists)]	
[Annual Benefit Maximum	[\$750][1,000] (combined for participating and	

(for covered persons age 19 and older)	non-participating dentists)]
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Annual Out of Pocket Maximum

For *covered persons* through the end of the month in which they turn 19, there is an annual out of pocket maximum. This amount is the most you will pay out of pocket in a *coverage year* for *essential health benefits* before we will pay 100% of the *maximum allowed amount* for *essential health benefits*. Your premium amount, charges for services that are not covered, or charges for services received from a *non-participating dentist* do not apply to the out of pocket maximum.

Annual Out of Pocket Maximum for 1 child.....	\$350
Annual Out of Pocket Maximum for 2 or more children	\$700

Coverage Percentages

After you have met any applicable *deductibles*, we pay the following percentages of the *maximum allowed amount* for *covered services*. The *maximum allowed amount* is different for *participating* and *non-participating dentists*. If you see a *non-participating dentist*, you may have more out-of-pocket expenses. To learn more about how the *maximum allowed amount* is determined, see the section called Dental Providers and Claims Payments.

Essential Health Benefits

The following benefits are available to *covered persons* through the end of the month in which they turn 19 only. You have to meet your *deductible* before we will pay for *covered services*. However, the *deductible* is waived for fluoride treatments.

Type of Service	Participating Dentists	Non-Participating Dentists
Diagnostic & Preventive Services	100%	[70][80]%
Basic Restorative Services	[60][80]%	[50][60]%
Endodontic Services	[50][80]%	50%
Periodontal Services	[50][80]%	50%
Oral Surgery Services	[50][80]%	50%
Major Restorative Services	50%	50%
Prosthodontic Services	50%	50%
Dentally Necessary Orthodontic Care	50%	50%
[Cosmetic Orthodontic Care	50%	50%]

Covered persons age 8 through age 18 may be eligible for Cosmetic Orthodontic Care if the recommended treatment is not eligible for Dentally Necessary Orthodontic Care. Cosmetic Orthodontic Care is not an Essential Health Benefit.

[Adult Dental Benefits

The following benefits are available to *covered persons* age 19 and older only. You have to meet your *deductible* before we will pay for *covered services*.

Type of Service	Participating Dentists	Non-Participating Dentists
Diagnostic & Preventive Services	100%	50%
Basic Restorative Services	[50][80]%	[25][40]%
Endodontic Services	[30][50]%	[15][25]%
Periodontal Services	[30][50]%	[15][25]%
Oral Surgery Services	[30][50]%	[15][25]%
Major Restorative Services	[30][50]%	[15][25]%

Prosthodontic Services
Orthodontic Services

[30][50]%
Not covered

[15][25]%
Not covered]

DEFINITIONS

This section defines terms that have special meanings within this booklet. Terms that are defined in this section will be italicized throughout the booklet. When you see an italicized word, you should refer to this section.

Benefit maximum – the maximum amount we will pay for covered services for each covered person during the coverage year. See the Summary of Dental Benefits for your benefit maximums.

Coinsurance - a percentage of the maximum allowed amount for which you are responsible. Your coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Coverage percentages - a percentage of the maximum allowed amount that we will pay for covered services.

Covered person - any person that is covered under this policy.

Covered services – services or treatments that are performed, prescribed, directed or authorized by a dentist. Covered services are listed in the Covered Services section. To be considered covered services, services must be:

- within the scope of the license of the dentist performing the service;
- given while you are covered under this policy;
- a service that is not excluded or limited under this policy; and
- not listed as a benefit within this booklet.

Coverage year – a 12 month period in which deductibles and benefit maximums apply. Your coverage year is January 1st through December 31st.

Deductible – the dollar amount you are responsible to pay each coverage year before we will pay for covered services. Your deductible amount is listed in the Summary of Dental Benefits.

Dentally necessary orthodontic care – a dental service where at least one of the following criteria are present: (A) There is spacing between adjacent teeth which interferes with the biting function; or (B) There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when the covered person bites; or (C) Positioning of the jaws or teeth impair chewing or biting function; or (D) On an objective professionally recognized dental orthodontic severity index the condition scores at a level consistent with the need for orthodontic care; or (E) Based on a comparable assessment of items (A) through (D), there is an overall orthodontic problem that interferes with the biting function.

Dentist – a person who is licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry.

[Dependent – a person in your family that is eligible for coverage under this policy. See the Eligibility and Termination section for more information.]

Effective date – the date your coverage begins under this policy.

Essential Health Benefits (EHB) – for the purposes of this coverage, Essential Health Benefits are those pediatric oral services that we are required to cover under the Patient Protection and Affordable Care Act and any other application regulations. EHB and its provisions apply to covered persons through the end of the month in which they turn 19 only.

Identification card / ID card – a card we issue to you that shows your name, your member ID number, and important phone numbers to contact us.

Maximum allowed amount – the maximum amount we will pay for covered services. See the section Dental Providers and Claims Payments for more information on how we determine the maximum allowed amounts.

Non-participating dentist – a dentist who has NOT signed a written agreement with us to service the program identified in this booklet.

Participating dentist – a dentist who has signed a written agreement with us to service the program identified in this booklet. *Participating dentists* have agreed to our maximum allowed amount as payment in full for covered services.

Policy – is the entire set of benefits, conditions, exclusions and limitations that make up your coverage. It consists of this booklet, your application, and any endorsements.

Policyholder – is the person who has applied and been accepted by us for coverage under this policy.

Premium – the periodic charges you must pay for coverage under this policy.

Waiting period - a waiting period is the length of time you must be covered under this policy before we pay benefits. See the Summary of Dental Benefits for your waiting periods.

DENTAL PROVIDERS AND CLAIMS PAYMENTS

You do not have to select a particular *dentist* to receive dental benefits. You have the freedom to choose the *dentist* you want for your dental care. However, your *dentist* choice can make a difference in the benefits you receive and the amount you pay. You may have additional out-of-pocket costs if your *dentist* is a *non-participating dentist*. There may be differences in the payment amount compared with a *participating dentist* if your *dentist* is a *non-participating dentist*.

We make payments only when the covered dental procedures have been completed. We may require additional information from you or your *dentist* before a claim can be considered complete and ready for processing. In order to properly process a claim, we may be required to add an administrative policy line to the claim. Duplicate claims previously processed will be denied.

This section describes how we determine the amount of reimbursement for *covered services*. Reimbursement for dental services rendered by *participating* and *non-participating dentists* is based on the *maximum allowed amount* for the type of service performed. There may be different levels of reimbursement for the *maximum allowed amount* depending upon whether you elect to receive services from a *participating* or a *non-participating dentist*.

The *maximum allowed amount* is the maximum amount of reimbursement we will pay for covered dental services provided by a *dentist* to a *covered person*. For *participating dentists*, the *maximum allowed amount* will be reimbursed according to the schedule of maximum allowable charges. For *non-participating dentists*, the *maximum allowed amount* will be reimbursed according to the table of allowances.

You will be required to pay a portion of the *maximum allowed amount* if you have not met your *deductible* or have a *coinsurance* due. In addition, when you receive *covered services* from a *non-participating dentist*, you may be responsible for paying any difference between the *maximum allowed amount* and the *dentist's* actual charges. This amount may be significant.

When you receive dental care from a *dentist*, we will apply processing rules to the claim submitted for that dental care. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the dental procedure. Applying these rules may affect our determination of the *maximum allowed amount*. For example, your *dentist* may have submitted the claim using several procedure codes when there is a single procedure code that includes all or a combination of the procedures that were performed. When this occurs, our payment will be based on the single *maximum allowed amount* for the single procedure code rather than a separate *maximum allowed amount* for each billed procedure code.

Likewise, when multiple procedures are performed on the same day by the same *dentist* or another *dentist*, we may reduce the *maximum allowed amount* for those additional procedures, because reimbursement at 100% of the *maximum allowed amount* for those procedures would represent a duplicate payment for a dental procedure that may be considered incidental or inclusive.

Participating Dentists

A *participating dentist* is a *dentist* who has signed a written provider service agreement agreeing to service the program identified in this *policy*. For *covered services* performed by a *participating dentist*, the *maximum allowed amount* is based upon the lesser of the *dentist's* actual charges or the schedule of maximum allowable charges. Because *participating dentists* have agreed to accept the *maximum allowed amount* as payment in full for services, they should not send you a bill or collect for amounts above the agreed upon *maximum allowed amount*. However, you may receive a bill or be asked to pay a portion of the *maximum allowed amount* if you have exhausted your coverage for the service, have not met your *deductible*, have a *coinsurance* due, have received *non-covered services*, or have exceeded the dental *benefit maximum* as outlined in the Summary of Dental Benefits. Please call customer service at (877) 604-2142 for help in finding a *participating dentist* or visit our website at www.anthem.com/mydentalvision.

Please refer to your *ID card* for the name of the dental program that participating providers have agreed to service when you are choosing a participating provider.

Non-Participating Dentists

Dentists who have NOT signed a written provider service agreement agreeing to service the program identified in this *policy* are considered *non-participating dentists*. For *covered services* you receive from a *non-participating dentist*, the *maximum allowed amount* will be the lesser of the *dentist's* actual charges or an amount based on our *non-participating dentist* fee schedule, referred to as the table of allowances, which we reserve the right to modify from time to time after considering one or more of the following: reimbursement amounts accepted by similar providers contracted with us, and other industry cost, reimbursement and utilization data. The table of allowances may be different from the *maximum allowed amount* reimbursed to *participating dentists*.

Unlike *participating dentists*, *non-participating dentists* may send you a bill and collect for the amount of the *dentist's* charge that exceeds the *maximum allowed amount*. You are responsible for paying the difference between the *maximum allowed amount* and the amount the *non-participating dentist* charges. This amount may be significant. Choosing a *participating dentist* will likely result in lower out of pocket costs to you. Please call customer service at (877) 604-2142 for help in finding a *participating dentist* or visit our website at www.anthem.com/mydentalvision.

Customer service is also available to assist you in determining the *maximum allowed amount* for a particular service from a *non-participating dentist*. In order for us to assist you, you will need to obtain the specific procedure code(s) from your *dentist* for the services the *dentist* will render. You will also need to know the *dentist's* charges to calculate your out of pocket responsibility. Although customer service can assist you with this pre-service information, the *maximum allowed amount* for your claim will be based on the actual claim submitted.

Your Cost Share

For certain *covered services* and depending on your dental program, you may be required to pay a part of the *maximum allowed amount* (for example, *deductible* and/or *coinsurance*). Your *deductible*, *coinsurance* and out-of-pocket costs may vary depending on whether you received services from a participating or *non-participating dentist*. Specifically, you may pay higher out-of-pocket costs when using *non-participating dentists*. Please see the Summary of Dental Benefits in this *policy* for your cost share responsibilities and limitations, or call customer service to learn how this *policy's* benefits or cost share amounts may vary by the type of *dentist* you use.

Payment of Benefits

You authorize us to make payments directly to *participating dentists* for *covered services*. We also reserve the right to make payments directly to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an alternate recipient, or that person's custodial parent or designated representative. Any payments made by us will discharge our obligation to pay for *covered services*.

Once a *dentist* gives a *covered service*, we will not honor a request for us to withhold payment of the claims submitted.

YOU ARE RESPONSIBLE FOR ALL TREATMENT CHARGES MADE BY A *NON-PARTICIPATING DENTIST*. WHEN SERVICES ARE OBTAINED FROM A *NON-PARTICIPATING DENTIST*, ANY BENEFITS PAYABLE UNDER THIS *POLICY* ARE PAID DIRECTLY TO YOU, UNLESS YOU HAVE ASSIGNED YOUR BENEFIT TO THE *DENTIST* WHO PROVIDED THE SERVICE.

COVERED SERVICES

All *covered services* are subject to the terms, limitations, and exclusions of your *policy*. See the Summary of Dental Benefits for your cost share amounts, such as *deductibles* and/or any *coinsurance*.

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are medically necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this *policy*. We evaluate the procedures submitted to us on your claim to determine if they are a *covered service* under this *policy*.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was *dentally necessary orthodontic care*. See the section Orthodontic Care for more information. [If it is determined the care is not *dentally necessary orthodontic care*, it may be covered at the cosmetic orthodontic care rate. See your Summary of Dental Benefits to determine if you have cosmetic orthodontic care coverage.]]

Your *dentist* may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this *policy*. While these services may be necessary for your dental condition, they may not be covered by us. There may be an alternative dental care service available to you that is covered under your *policy*. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your *dentist*. You are responsible for any costs that exceed the allowance, in addition to any *coinsurance* or *deductible* you may have.

The decision as to what dental care treatment is best for you is solely between you and your *dentist*.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your *dentist*. It provides you and the *dentist* with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the *dentist* and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, endodontic, periodontic, oral surgery, prosthodontic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the *policy* benefits in effect at the time the estimate is submitted to us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the *policy* may affect our final payment.

You can ask your *dentist* to submit a pretreatment estimate for you, or you can send it to us yourself. Please include the procedure codes for the services to be performed (your *dentist* can tell you what procedure codes). Pretreatment estimate requests can be sent to the address on your dental *ID card*.

Pediatric Dental Essential Health Benefits

We cover the following dental care services for *covered persons* through the end of the month in which they turn 19 when they are performed by a licensed *dentist*, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, we will cover the least expensive.

Preventive Care (Diagnostic and Preventive Services)

Oral Evaluations - Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

NOTE: Comprehensive oral evaluations will be covered 1 time per dental office, subject to the 2 times per calendar year limitation. Any additional comprehensive oral evaluations performed by the same dental office will be covered as a periodic oral evaluation and will be subject to the 2 times per calendar year limitation.

Radiographs (X-rays)

- Bitewings - Covered at 1 series of bitewings per 6-month period for members through the age of 17; 1 series per 12 months for members age 18 and over.
- Full Mouth (Complete Series) - Covered 1 time per 60-month period.
- Panoramic – covered 1 time per 60-month period.
- Periapical(s)
- Occlusal
- Extraoral film

Dental Cleaning (Prophylaxis) – Covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

NOTE: A prophylaxis performed on a member under the age of 14 will be covered as a child prophylaxis. A prophylaxis performed on a member age 14 or older will be covered as an adult prophylaxis.

Fluoride Treatment (Topical application of fluoride) - Covered 2 times per calendar year.

Fluoride Varnish - Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered 1 time per 24-month period for permanent first and second molars.

Space Maintainers

Recement Space Maintainer

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Services

Consultations (other than dentist providing treatment)

Office Visits

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary posterior (back) teeth.

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth.

- **Anterior (front) Teeth** - Treatment to restore decayed or fractured permanent or primary anterior (front) teeth.
- **Posterior (back) Teeth** - Treatment to restore decayed or fractured permanent or primary posterior (back) teeth. Benefits shall be limited to the same surfaces and allowances for amalgam (silver filling). The patient must pay the difference in cost between the plan's maximum allowed amount for the covered benefit and the dentist's submitted fee for the optional treatment, plus any deductible and/or coinsurance that applies.

Periodontal Maintenance - A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of teeth, periodontal evaluation and gum pocket measurements for patients who have completed previous surgical or nonsurgical periodontal treatment.

LIMITATION: Any combination of this procedure and dental cleanings (see Diagnostic and Preventive section) is covered 4 times per 12-month period.

Endodontic Therapy on Primary Teeth

- **Pulpal Therapy**
- **Therapeutic Pulpotomy**

Basic Non Surgical Periodontal Care - Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- **Periodontal scaling & root planing** - Covered 1 time per quadrant per 24 months.

Resin based composite resin crown, anterior - Covered 1 time per 24-month period.

Partial Pulpotomy for apexogenesis - Covered 1 time per lifetime on permanent teeth only.

Pin Retention

Prefabricated or Stainless Steel Crown – Covered 1 time per 60-month period through age 14.

Therapeutic Drug Injection

Fabrication of Athletic Mouthguard

Internal Bleaching

Basic Endodontic Services (Nerve or Pulp Treatment)

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments.

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation
- Hemisection Retrograde filling

Periodontics (Gum and Bone Treatment)

Basic Non Surgical Periodontal Care - Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Full mouth debridement - Covered 1 time per lifetime.

Complex Surgical Periodontal Care - Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

LIMITATION: Only 1 complex surgical periodontal service is covered per 36-month period per single permanent tooth or multiple teeth in the same quadrant.

Crown Lengthening - Covered once per lifetime.

Chemotherapeutic Agents

Oral Surgery (Tooth, Tissue, or Bone Removal)

Basic Extractions

- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth

- Surgical removal of residual tooth roots

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collect – apply autologous product - Covered 1 time per 36-month period.
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation – accidentally evulsed or displaced tooth
- Suture of recent small wounds up to 5 cm

General Anesthesia, Intravenous Conscious Sedation and IV Sedation - Covered when performed in conjunction with complex surgical service.

LIMITATION: General anesthesia, intravenous conscious sedation and IV sedation will not be covered when performed with non-surgical dental care.

Major Restorative Services

Services performed to restore lost tooth structure as a result of decay or fracture

Gold foil restorations - Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances. The patient must pay the difference in cost between the maximum allowed amount for the covered service and the dentist's submitted fee for the optional treatment, plus any deductible and/or coinsurance that applies.

Inlays - Benefit will equal an amalgam (silver) restoration for the same number of surfaces.

LIMITATION: If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the maximum allowed amount for the amalgam restoration and the inlay, plus any deductible and/or coinsurance that applies.

Onlays and/or Permanent Crowns - Covered 1 time per 5-year period per tooth if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only.

LIMITATION: We will pay up to the maximum allowed amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any deductible and/or coinsurance that applies.

Implant Crowns - See Prosthodontic Services.

Recement Inlay, Onlay and Crowns - Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair - Covered 1 time per 12-month period per tooth when the submitted narrative from the treating dentist supports the procedure.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface - Covered 1 time per 5 years when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown – Covered 1 per tooth every 60 months.

Occlusal Guards – Covered 1 per 12 months for members age 13 through 18.

Prosthodontic Services (Dentures, Partial, and Bridges)

Tissue Conditioning

Reline and Rebase - Covered 1 time per 36-month period:

- When the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- Only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Clasp(s)

Replacement of Broken Artificial Teeth - Covered 2 times per 24-month period:

- When the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- Only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments

Partial and Bridge Adjustments

Removable Prosthodontic Services (Dentures and Partial) - Covered 1 time per 5 year period:

- For the replacement of extracted (removed) permanent teeth;
- If 5 years have elapsed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthodontic Services (Bridge) - Covered 1 time per 5 year period:

- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have elapsed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

LIMITATION: If there are multiple missing teeth, a removable partial denture may be the benefit since it would be the least costly, commonly performed course of treatment. The optional benefit is subject to all contract limitations on the covered service.

Recement Fixed Prosthetic

Single Tooth Implant Body, Abutment and Crown - Covered 1 time per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

LIMITATION: Some adjunctive implant services may not be covered. It is recommended that a pretreatment estimate be requested to estimate the amount of payment prior to beginning treatment.

Orthodontic Care - 24 Month Waiting Period

Orthodontic Treatment is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. [We will only cover orthodontic care that is Dentally Necessary Orthodontic Care.] You should submit your treatment plan to us before you start any orthodontic treatment to make sure it is covered under this [plan/policy].

Dentally Necessary Orthodontic Care

To be considered Dentally Necessary Orthodontic Care, at least one of the following criteria must be present:

- a. There is spacing between adjacent teeth which interferes with the biting function;
- b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
- c. Positioning of the jaws or teeth impair chewing or biting function;
- d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
- e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

Orthodontic treatment may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts/models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Complex Surgical Procedures – surgical exposure of impacted or unerupted tooth for orthodontic reasons; or surgical repositioning of teeth.

Note: Treatment in progress (appliances placed prior to being covered under this [plan/policy]) will be benefited on a pro-rated basis.

Orthodontic Exclusions

Coverage is NOT provided for:

- Monthly treatment visits that are inclusive of treatment cost;
- Repair or replacement of lost/broken/stolen appliances;
- Orthodontic retention/retainer as a separate service;

- Retreatment and/or services for any treatment due to relapse;
- Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
- Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, payments are made over the course of your treatment. You must have continuous coverage under this plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this coverage ends.

Before treatment begins, the treating dentist should submit a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your dentist indicating the estimated maximum allowed amount, including any amount (coinsurance) you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the dentist should submit the Estimate of Benefit form with the date of appliance placement and his/her signature. After benefit and eligibility verification by us, a payment will be issued. A new/revised Estimate of Benefits form will also be issued to you and your dentist. This again will serve as the claim form to be submitted 6 months from the date of appliance placement.

[Adult Dental We cover the following dental care services for covered persons age 19 and older when they are performed by a licensed *dentist*, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, we will cover the least expensive.]

Diagnostic and Preventive Services

Oral Evaluations - Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Radiographs (X-rays)

- **Bitewings** - Covered at 1 series of bitewings per 24-month period.
- **Full Mouth (Complete Series) or Panoramic** - Covered 1 time per 60-month period.
- **Periapical(s)** - 4 single x-rays are covered per 12-month period.
- **Occlusal** - Covered at 2 series per 24-month period.

Dental Cleaning (Prophylaxis) - Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth. Any combination of this procedure and Periodontal Maintenance (See Periodontal Services) are covered 2 times per calendar year.

Basic Restorative Services

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth.

Composite (white) Resin Restorations

- Anterior (front) Teeth - Treatment to restore decayed or fractured permanent or primary anterior (front) teeth.
- Posterior (back) Teeth - Treatment to restore decayed or fractured permanent or primary posterior (back) teeth.

Benefits will be limited to the same surfaces and allowances for amalgam (silver filling). The patient must pay the difference in cost between the *maximum allowed amount* for the *covered service* and the optional treatment, plus any *deductible* and/or *coinsurance* that applies.

LIMITATION: Coverage for amalgam or composite restorations will be limited to 1 service per tooth surface per 24-month period.

Basic Extractions

- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Brush Biopsy - Covered 1 time per 36-month period, per *covered person* age 20 to 39. Covered 1 time per 12-month period per *covered person* age 40 and above.

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy
- Therapeutic Pulpotomy

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

LIMITATION: All of the above procedures are covered 1 time per tooth per lifetime.

Periodontal Services

Periodontal Maintenance - A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed previous surgical or nonsurgical periodontal treatment.

LIMITATION: Any combination of this procedure and dental cleanings (see Diagnostic and Preventive section) is covered 2 times per calendar year.

Basic Non Surgical Periodontal Care - Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planing - Covered 1 time per 36 months if the tooth has a pocket depth of 4 millimeters or greater.
- Full mouth debridement - Covered 1 time per lifetime.

Complex Surgical Periodontal Care - Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services under this *policy*.

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

LIMITATION: Only 1 complex surgical periodontal service is covered per 36-month period per single tooth or multiple teeth in the same quadrant and only if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

LIMITATION: Surgical removal of 3rd molars is only covered if the removal is associated with symptoms or oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

LIMITATION: The Other Complex Surgical Procedures are covered only when required to prepare for dentures and is a benefit covered once in a 60-month period.

Surgical Reduction of Fibrous Tuberosity - Covered 1 time per 6-months.

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation and General Anesthesia - Covered when performed in conjunction with complex surgical services.

Major Restorative Services

Gold foil restorations - Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances.

LIMITATION: The patient must pay the difference in cost between the *maximum allowed amount* for the *covered services* and optional treatment, plus any *deductible* and/or *coinsurance* that applies. Covered 1 time per 24-month period.

Inlays - Benefit will equal an amalgam (silver) restoration for the same number of surfaces.

LIMITATION: If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the *maximum allowed amount* for the *covered service* and optional treatment, plus any *deductible* and/or *coinsurance* that applies.

Onlays and/or Permanent Crowns - Covered 1 time per 7 year period if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth.

LIMITATION: Porcelain/ceramic substrate onlays/crowns – Benefits will be limited to the *maximum allowed amount* for a porcelain to noble metal crown. The patient must pay the difference in cost between the *maximum allowed amount* for the *covered service* and optional treatment, plus any applicable *deductible* and/or *coinsurance*.

Implant Crowns - See Prosthodontic Services.

Recement Inlay, Onlay and Crowns - Covered 6 months after initial placement.

Crown Repair - Covered 1 time per 12-month period per tooth when the submitted narrative from the treating *dentist* supports the procedure.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface - Covered 1 time per 7 year period when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prosthodontic Services

Tissue Conditioning - Covered 1 time per 24-month period.

Reline and Rebase - Covered 1 time per 24-month period:

- When the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- Only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) - Covered 1 time per 6-month period:

- When the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- Only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating *dentist* supports the procedure.

Denture Adjustments - Covered 2 times per 12-month period:

- When the denture is the permanent prosthetic appliance; and
- Only after 6 months following initial placement of the denture.

Partial and Bridge Adjustments - Covered 2 times per 24-month period:

- When the partial or bridge is the permanent prosthetic appliance; and
- Only after 6 months following initial placement of the partial or bridge.

Removable Prosthodontic Services (Dentures and Partials) - Covered 1 time per 7 year period:

- For the replacement of extracted (removed) permanent teeth;
- If 7 years have elapsed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthodontic Services (Bridge) - Covered 1 time per 7 year period:

- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 7 years;
- If 7 years have elapsed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

LIMITATION: If there are multiple missing teeth, a removable partial denture may be the benefit since it would be the least costly, commonly performed course of treatment. The optional benefit is subject to all contract limitations on the *covered service*.

Recement Fixed Prosthetic - Covered 1 time per 12 months.

Single Tooth Implant Body, Abutment and Crown - Covered 1 time per 7 year period for *covered persons* age 16 and over. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

LIMITATION: Some adjunctive implant services may not be covered. It is recommended that a Pretreatment Estimate be requested to estimate the amount of payment prior to beginning treatment.]

Exclusions

Coverage is NOT provided for:

- [Dental care for *covered persons* age 19 and older.]
- Dental services which a *covered person* would be entitled to receive for a nominal charge or without charge if this coverage were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a *covered person* receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this *policy* will not be reduced or denied because dental services are rendered to a subscriber or *dependent* who is eligible for or receiving medical assistance.
- Dental services or health care services not specifically covered under the plan (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).
- New, experimental or investigational dental techniques or services may be denied until there is, to our satisfaction, an established scientific basis for recommendation.
- Dental services completed prior to the date the *covered person* became eligible for coverage.
- Services of anesthesiologists.
- Anesthesia Services, except when given with covered complex surgical services and given by a *dentist* or by an employee of the *dentist* when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Dental services performed other than by a licensed *dentist*, licensed physician, his or her employees.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Case presentations.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Enamel microabrasion and odontoplasty.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the *policy*.
- Bacteriologic tests.
- Cytology sample collection.
- Separate services billed when they are an inherent component of another *covered service*.
- Services for the replacement of an existing partial denture with a bridge.
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Provisional splinting, temporary procedures or interim stabilization.

- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Incomplete root canals.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Amalgam or composite restorations, inlays, onlays and/or crowns placed for preventive or cosmetic purposes.
- Temporomandibular Joint Disorder (TMJ) except as covered under your medical coverage.
- Oral hygiene instructions.
- Repair or replacement of lost/broken appliances are not a covered benefit.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.

Additional exclusions to be added when offering adult dental coverage

- [Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.]
- [Initial installation of an implant(s), full or partial dentures or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a *covered person* under this *policy*. EXCEPTION: This exclusion will not apply for any person who has been continuously covered for more than 24 months.]
- [For *covered persons* age 19 and older, corrections of congenital conditions during the first 24 months of continuous coverage under this *policy*.]
- [Dental implant maintenance or repair to an implant or implant abutment.]
- [Orthodontic services for *covered persons* age 19 and older.]

ELIGIBILITY AND TERMINATION

This section will tell you who is eligible for coverage under this *policy* and how to add or remove *dependents* from your *policy*. It will also give you information about how your coverage ends under this *policy*.

[IMPORTANT NOTE: This policy DOES NOT provide coverage for any dental benefits for individuals age nineteen (19) or older. If you are age 19 or older, you may enroll in this policy so you will have the pediatric dental coverage as required by the Affordable Care Act. If you want coverage for adult dental care, you will need to buy a different plan.]

Who is Eligible

Policyholder

To be a *policyholder*, the applicant must meet the following requirements:

- a) Be determined by the Exchange to be a Qualified Individual for enrollment in a Qualified Health Plan (QHP).
- b) Be a United States citizen or national; or
- c) Be a lawfully present non-citizen for the entire period for which coverage is sought; and
- d) Be a Maine resident;
- e) Submit proof satisfactory to Anthem to confirm *dependent* eligibility;
- f) Agree to pay for the cost of *premium* that Anthem requires;
- g) Reveal any coordination of benefits arrangements or other dental benefit arrangements for the applicant or *dependents* as they become effective;
- h) Not be incarcerated (except pending disposition of charges);
- i) Not be covered by any other group or individual dental plan.

For a Qualified Individual age 21 and over, the applicant must:

- Not be living in an institution;
- Be capable of indicating intent;
- Not be receiving optional State Supplementary Payments (SSP); and
- Reside in the service area of the Exchange.

For a Qualified Individual under age 21, the applicant must:

- Not be living in an institution;
- Not be eligible for Medicaid based on the receipt of federal payments for foster care and adoption assistance under Social Security;
- Not be emancipated;
- Not be receiving optional State Supplementary Payments (SSP); and reside in the service area of the Exchange.

For purposes of Eligibility, a Qualified Individual's service area is the area in which the Qualified Individual:

1. Resides, intends to reside (including without a fixed address); or
2. Has entered without a job commitment

For Qualified Individuals under age 21, the service area is that of the parent or caretaker with whom the Qualified Individual resides.

For tax households with *covered persons* in multiple Exchange service areas:

1. If all of the members of a tax household are not living within the same Exchange service area, any member of the tax household may enroll in a Qualified Health Plan through any of the Exchanges for which one of the tax filers meets the residency requirements.
2. If both spouses in a tax household enroll in a Qualified Health Plan through the same Exchange, a tax dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the dependent meets a residency standard.

Dependents

To be enrolled as a *dependent*, you must be listed on the enrollment form completed by the *policyholder*, be determined by the Exchange to be a Qualified Individual, and meet all *dependent* eligibility criteria. The following *dependents* of a *policyholder* may be enrolled under this *policy*:

1. Spouse, meaning:
 - a. Married
 - b. Qualified domestic partner, if all of the following criteria are met:
 - i. are not related by blood closer than permitted under applicable state marriage laws;
 - ii. are not married and do not have any other domestic partners;
 - iii. are at least 18 years of age and have the capacity to enter in a contract;
 - iv. share a residence;

All references to spouses in this *policy* will include domestic partners.

2. *Dependent* children up to the age of 26, including:
 - a. You and your spouse's natural-born and legally adopted children.
 - b. Children for whom you or your spouse are the legal guardian.
 - c. Stepchildren.
3. Disabled children who have reached age 26 if:
 - a. they are primarily dependent upon you or your spouse;
 - b. they are incapable of self sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability; and
 - c. were disabled before they reached age 26.

The Exchange may require the *policyholder* to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Newborn and Adopted Child Coverage

Newborn children of the *policyholder* or the *policyholder's* spouse will be covered for an initial period of 60 days from the date of birth. Coverage for newborns will continue beyond the 60 days, provided the *policyholder* submits through the Exchange a form to add the child under the *policyholder's* contract. The form must be submitted along with the additional *premium*, if applicable, within 60 days after the birth of the child.

A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enrollee your child under this *policy*, and the child is otherwise eligible for the coverage, you must request permission from the Exchange for your child to enroll under this *policy*, and once approved by the Exchange, we will provide the benefits of this *policy* in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any *dependent* age limit. Any claims payable under this *policy* will be paid, at our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to us directly.

Family Status Change

If you experience one of the above eligible family status changes during the year, you have 31 days from the event to change your elections. If you need to make changes to your *policy* due to a family status change, you should contact customer service at the number listed on your ID card to obtain an Enrollment Change Form.

Open Enrollment

As established by the rules of the Exchange, Qualified Individuals are only permitted to enroll in a Qualified Health Plan (QHP), or as an enrollee to change QHPs, during the annual open enrollment period or a special enrollment period for which the Qualified Individual has experienced a qualifying event.

An annual open enrollment period is provided for Qualified Individuals and enrollees. Qualified Individuals may enroll in a QHP, and enrollees may change QHPs at that time according to rules established by the Exchange.

American Indians are authorized to move from one QHP to another QHP once per month.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, a QHP through the Exchange, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Qualified Individual or enrollee has 60 calendar days from the date of a triggering event to select a QHP.

The Exchange must allow Qualified Individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

- A Qualified Individual or *dependent* loses his or her Minimum Essential Coverage. The term Minimum Essential Coverage means any of the following: Government sponsored programs; coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a state; coverage under a grandfathered health plan, and such other health benefits coverage, such as a state health benefits risk pool, or as the Secretary of HHS recognizes);
- A Qualified Individual gains a *dependent* or becomes a *dependent* through marriage, birth, adoption or placement for adoption;
- An individual, not previously a citizen national, or lawfully present gains such status;
- A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error of the Exchange or the Department of Health and Human Services (HHS), or its instrumentalities as determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for Cost-Sharing reductions, regardless of whether such individual is already enrolled in a QHP;
- The Exchange must permit individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming Plan Year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A Qualified Individual or enrollee gains access to new QHPs as a result of a permanent move; and

A Qualified Individual or enrollee demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Exchange may provide

Policy Effective Date

Your policy will begin on the *effective date*, which is the first day of the coverage year following your selection made during the Exchange's annual open enrollment period. Your actual effective date will be determined by the date you submit a completed application and pay any applicable premiums to the Exchange.

Effective dates for special enrollment period:

1. In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption. Advance Payments of the Premium Tax Credit are not effective until the first day of the following month in which you provided notice, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and
2. In the case of marriage, or in the case where a Qualified Individual loses his or her Minimum Essential Coverage, coverage is effective on the first day of the month following the event, as long as the application is received within 30 days of the event.

Termination

When Your Coverage Ends

Your coverage and that of your *dependents* will end on the earliest of the following dates:

1. The date determined by the Exchange as a result of you requesting termination with appropriate notice to the Exchange or the QHP;
2. The end of the month in which you are no longer eligible;
3. [The end of the month in which your *dependent* is no longer a *dependent* as defined in this policy;]
4. The last day of the month for which a *premium* has not been paid, subject to the grace period; or
5. The date the policy ends as determined by the Exchange. You will be notified by the QHP as required by law.

[When a Child's Coverage Ends

Covered children will receive benefits for the *essential health benefits* in this *policy* until the end of the month in which they turn age 19. This *policy* does not cover adult dental benefits. However, those 19 and older may be continue to be enrolled in this *policy* so they will have pediatric dental coverage as required by the Affordable Care Act.]

[When a Child's Coverage Ends

Covered children will receive benefits for the *essential health benefit* coverage in this policy until the end of the month in which they turn age 19. At the end of the month in which they turn 19, unless we are given notice to cancel, they will be covered under the Adult Dental Benefits in this *policy* to the end of the month in which they reach age 26, unless they are disabled. Please see the Who is Eligible section for more information.]

Cancelling Your Policy

You may cancel this policy at any time by written notice delivered or mailed us; effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, we will return promptly the unearned portion of any *premium* paid. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation. [If you elect coverage and subsequently cancel your *policy*, you and your *dependents* will not be allowed to re-enroll in the *policy* [for a period of [12 – 24] months from the date your *policy* was cancelled].

Notification Prior to Termination

You have the right to designate an individual of your choice, or to change this designation, to receive a notification that your coverage under the *policy* will terminate 10 days prior to the date the *policy* terminates. If you request a third party designation form, it will be mailed to you within 10 days of your request. In the event that your coverage under the *policy* is terminating due to non-payment of *premium* due to a cognitive impairment or functional incapacity, your coverage may be reinstated. You or a person authorized to act on your behalf, must request reinstatement within 90 days after termination. Upon reinstatement, you will have 15 days to pay any unpaid *premium* from the date of the last *premium* payment at the rate that would have been in effect had the *policy* not been terminated. If you do not pay the unpaid *premium* in within this time, your coverage may not be reinstated and we are not responsible for claims incurred after the initial date of cancellation.

Renewability

This *policy* will continue as long as your *premiums* are paid, subject to the grace period and you continue to be a Qualified Individual as determined by the Exchange.

We reserve the right to terminate the *policy*, in whole or in part, at any policy renewal date by giving you written notice at least 31 days prior to the renewal date. Termination of the *policy* will result in loss of coverage for all *covered persons*. If the *policy* is terminated, the rights of the *covered persons* are limited to *covered services* incurred before termination. Termination is without prejudice to any claim originating while the *policy* was in force.

We will not increase the *premiums* or decrease the benefits provided in this *policy* before any renewal date, and not without 30 days prior written notice.

Reinstatement

If your *policy* is terminated because you do not pay your *premium* within the grace period you may have it reinstated. Your *policy* will be reinstated if we, or an agent authorized by us, accept your *premium* payment after we have terminated your *policy*. If we accept your *premium*, we will not require an application to reinstate your *policy*.

However, we may ask for a new application to accept your premium and reinstate your *policy*. If we ask for a new application we will only re-instate your *policy* after we approve your application. We will notify you if we do not approve of your application within 45 days. If we do not notify you within 45 days after we received your application, it will be deemed approved.

If your *policy* is reinstated, only dental care received after the reinstated date will be covered. Your rights will be the same and will not change due to the reinstatement. We will apply the reinstated *premium* to the period for which the *premium* was not paid. However, we will not apply *premium* to any period over 60 days prior to reinstatement.

HOW TO FILE CLAIMS

A claim must be filed in order for us to pay for *covered services*. Most *dentists* will file your claim for you. If your *dentist* does not file the claim, you must file your claim with us. This section will tell you how to file a claim.

Notice of Claim

We must receive written notice of claim within 20 days from the date you received dental care. If it was not reasonably possible to send the notice within that time, send it to us as soon as is reasonably possible. Notice given to us, or an agent authorized by us, with information sufficient to identify you will meet the notice of claim requirements. If the notice does not include sufficient data we need to process the claim, the necessary data must be submitted to us within the time frames specified below or no benefits will be payable except as required by law.

Claim Forms

Many *dentists* will file the claim form for you. If the forms are not available, either send a written request for claim forms to us or contact customer service and ask for a claim form to be sent to you. The form will be sent to you within 15 days. If you do not receive the claim forms, you can send us other documents as your proof of claim. Your proof of claim must have the following:

- Name of patient
- Patient's relationship to you
- Identification number
- Date, type and place of service
- Your signature and the *dentist's* signature

We accept the standard American Dental Association (ADA) claim form used by most *dentists*.

Proof of Claim

We must receive your written proofs of claim within 20 days after the date you received dental care. If proof of claim is not sent within that time, your claim will not be reduced or denied, as long as it was not possible to send your proof. However, you must send it as soon as reasonably possible. In any case, the proof of claim must be sent to us no later than 15 months after the date of service, unless you were legally incapacitated.

Time of Payment of Claim

Any payments for *covered services* will be made as soon as possible upon receipt of proper written proof of claim, but no later than 30 days.

If more information is needed to process your claim, an extension of up to 30 days may be requested. The request for more information will be sent to you before the end of the initial twenty (20) days and will itemize the information or documents we need. You will have 15 working days after you receive the request to provide us with the information. We will make a claim decision within 30 days after we receive the requested information. Without complete information, your claim will be denied.

In the event the claim is denied, we will send notice within 30 days after we receive written proof of claim. The notice will tell you the reason(s) the claim was denied.

If we do not respond within the time frames stated above, we are responsible to pay the applicable interest on the payments due.

Address for Claims

Please send completed claim forms and any proofs of claim to the following address:

Anthem Blue Cross and Blue Shield
[PO Box 1115
Minneapolis, MN 55440-1115
(877) 604-2158]

HOW TO FILE AN APPEAL

This section explains and offers instructions on what to do if you disagree with a denial or modification of benefits for a dental claim, or are dissatisfied with the dental treatment or a service rendered by either a *dentist* or by us, and wishes to file a grievance or appeal.

Grievances

If you are dissatisfied, you may file a grievance with us verbally or in writing. If you have a grievance about any aspect of our service, such as the processing of a dental claim, a benefit determination, or *premium* billing, or the dental treatment or services rendered by a *dentist*, they may contact customer service at the toll free number listed below or on your *ID card*.

Anthem Blue Cross and Blue Shield
Attention: Appeals Unit
[PO Box 1122
Minneapolis, MN 55440-1122]

We will acknowledge receipt of the grievance and provide a resolution within the state's specified grievance resolution time frames. If you are not satisfied with the resolution of the grievance, an appeal may be filed as explained in the appeals section below:

Appeals

You may file an appeal verbally or in writing. We will acknowledge receipt of the appeal and provide a resolution within the state's specified appeal resolution time frames. An appeal may be filed for any dental claim that has been denied in whole or in part or to request a reconsideration for any adverse grievance decision. In the appeal, please state plainly the reason(s) why the treatment or service should not have been denied or why the adverse grievance decision should be reversed. All appeals will be reviewed by an individual not previously involved in the original decision. Reviews involving clinical judgment will be reviewed by a qualified clinical reviewer. Please include any documents or information that may have a bearing on our decision in our review but were not previously available to us.

Please send written appeals to the following address or contact us at the toll-free phone number listed below:

Anthem Blue Cross and Blue Shield
Attention: Appeals Unit
[PO Box 1122
Minneapolis, MN 55440-1122]

You may designate a representative (e.g., the health care provider or anyone else of your choosing) to file a grievance or appeal on your behalf. We must receive a written designation before working with the representative.

The grievance and appeals process is governed by laws and regulations, and may be modified from time to time by us as those laws may require.

Both TTY/TDD services for the hearing and speech impaired and language translation assistance are available upon request to assist you in filing a grievance or appeal.

GENERAL POLICY PROVISIONS

Premium Calculations and Payment

The payment of any *premium* will keep the coverage in force until the next *premium* due date, subject to the grace period provision of the *policy*.

Your *premium* amount, the *premium* payment schedule and the payment method is stated on the Policy Confirmation that you received following your enrollment.

We may change the *premium* for this *policy* by giving you a written notice of at least 60 days prior to any change.

For *premium* and payment questions, call [(877) 604-2158].

Grace Period

You have a grace period of 31 days to pay your *premium*. This *policy* will remain in effect during the grace period.

Entire Contract; Changes

This *policy*, including any endorsements or attached papers, is the entire contract of insurance. Its terms can be changed only a written endorsement signed by one of our authorized officers. No agent or employee of ours is authorized to change the terms or waive any other the provisions of this *policy*.

Time Limit on Certain Defenses

After you have been insured under this *policy* for 3 consecutive years, we will not use any material misstatements you may have made in your application for this *policy*, except any fraudulent misstatements, to either void this *policy* or to deny a claim for any *covered services* incurred after the expiration of such 3 year period.

Legal Actions

No action at law or in equity will be brought to recover on this *policy* sooner than 60 days after written proof of claim has been furnished in accordance with the requirements of this *policy*. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Misstatement of Age

If a *covered person's* age or sex has been misstated, we will adjust the *premiums* and/or benefits under this contract. The benefits will be the amount the *premiums* paid would have purchased at the correct age and/or sex.

Conformity to Law

The laws of the State of Maine will be used to interpret any of this *policy*.

Clerical Error

Clerical error by us will not invalidate insurance otherwise validly in force nor continue insurance otherwise terminated.

Dental Examination

We have the right to have a *dentist* examine you, at our own expense, as often as is reasonably required while processing a claim under this *policy*. We also have the right to make an autopsy in the case of death, where it is not prohibited by law.

Change in Beneficiary

You can change your beneficiary at any time by giving us written notice. The beneficiary's consent is not required for this or any other change in the *policy*, unless the designation of the beneficiary is irrevocable.

Coordination of Benefits

We do not coordinate benefits.

CONTACT US

CUSTOMER SERVICE DEPARTMENT

[(877) 604-2158]

Hours: 8:00 am to 4:30 pm Central Time
Monday - Friday

For claims and eligibility:

Anthem Blue Cross and Blue Shield
[PO Box 1115
Minneapolis, MN 55440-1115]

Send your appeal to:

Anthem Blue Cross and Blue Shield
Attention: Appeals Unit
[PO Box 1122
Minneapolis, MN 55440-1122]

Our website:

www.anthem.com